CREATING OPPORTUNITIES: A PLAN FOR ADVANCING COMMUNITY-FOCUSED SERVICES IN VIRGINIA

Implementation Update

Virginia Department of Behavioral Health and Developmental Services

April 13, 2011

CREATING OPPORTUNITIES: A PLAN FOR ADVANCING COMMUNITY-FOCUSED SERVICES IN VIRGINIA

IMPLEMENTATION UPDATE

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CREATING OPPORTUNITIES: A PLAN FOR ADVANCING COMMUNITY-FOCUSED SERVICES IN VIRGINIA IMPLEMENTATION ACTION STEPS

EXECUTIVE SUMMARY

Since the Department of Behavioral Health and Developmental Services (DBHDS) *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia* was issued in June 2010, significant progress has been made in defining the specific actions required to successfully implement the following strategic initiatives and major DBHDS activities:

Behavioral Health Services Strategic Initiatives

1. Strengthen the responsiveness of the emergency response system and maximize the consistency, availability, and accessibility of services for individuals in crisis across Virginia.
2. Develop infrastructure to increase peers in direct service roles and expand recovery support services.
3. Enhance access to a consistent array of substance abuse treatment services across Virginia.
4. Review and develop strategies to enhance the effectiveness and efficiency of state hospital services.
5. Develop and implement a comprehensive plan for child and adolescent mental health services.

Developmental Services Strategic Initiatives

1. Build community services and supports capacity that will enable individuals who need developmental services and supports, including those with multiple disabilities, to live a life that is fully integrated in the community.
2. Provide leadership and participate in interagency planning currently underway to identify responsibility at the state level for coordinating and providing services to individuals with development disabilities including autism spectrum disorders.

System-Wide Strategic Initiatives:

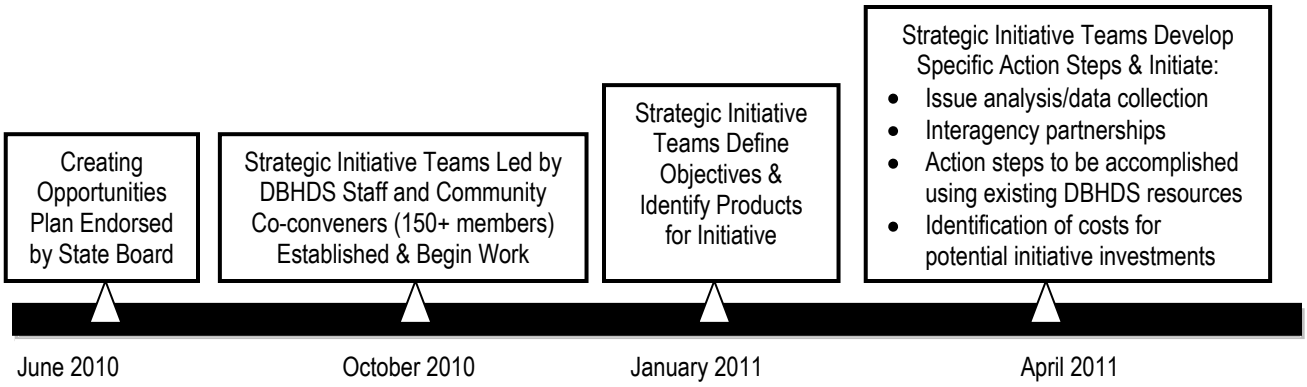
1. Address housing needs for individuals with mental health or substance use disorders and individuals with developmental disabilities through involvement in and support of the Governor’s initiative to reduce homelessness and expand affordable housing.
2. Create employment opportunities for individuals with mental health or substance use disorders and those with developmental disabilities in support of the Governor's Economic Development and Job Creation Commission.
3. Strengthen the capability of the case management system to support individuals receiving behavioral health or developmental services.

Other Major Strategic Initiatives:

1. Participate in the work of the Secretary of Health and Human Resources' Office of Health Care Reform and develop strategies to strengthen collaboration between the preventive and primary health care and the behavioral health and developmental services systems;
2. Address sexually violent predator (SVP) service capacity issues, including obtaining necessary resources to safely operate the Virginia Center for Behavioral Rehabilitation and provide appropriate SVP rehabilitation and treatment services; and

3. Develop information technology initiatives to implement electronic health records (EHR) and health information exchange (HIE) with state facilities, CSBs, other pertinent healthcare and provider agencies, facilitate quality management, and perform quality management and outcomes oversight.

Although the work of the strategic initiative teams is at varying stages of completion, the following timeline depicts overall progress of the Creating Opportunities strategic initiative to date:



CREATING OPPORTUNITIES: A PLAN FOR ADVANCING COMMUNITY-FOCUSED SERVICES IN VIRGINIA

IMPLEMENTATION ACTION STEPS

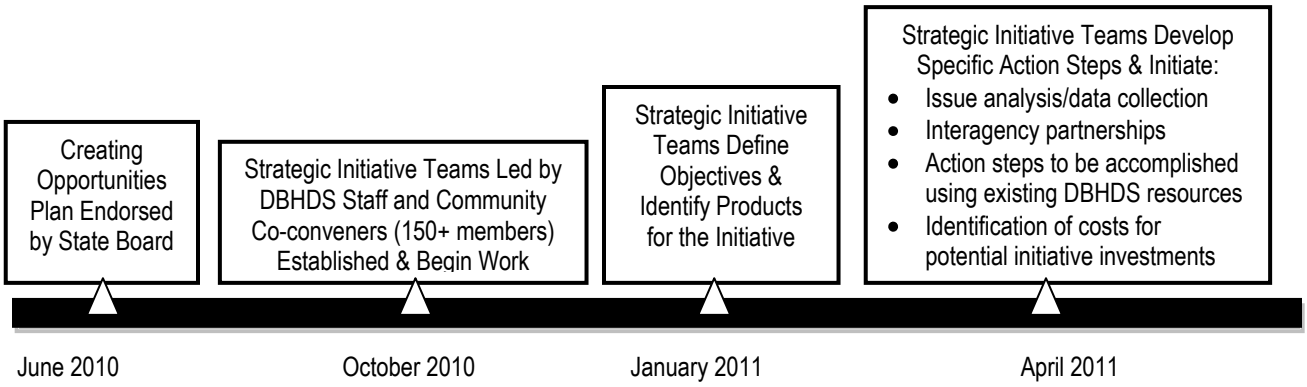
I. Introduction

CREATING OPPORTUNITIES STRATEGIC PLAN PURPOSE

The Department of Behavioral Health and Developmental Services (DBHDS) *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia* identifies behavioral health and developmental services goals, strategic initiatives, and major DBHDS activities to continue progress in advancing the DBHDS vision of a system of behavioral health and developmental services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of participation by individuals receiving services in all aspects of community life.

PROGRESS TIMELINE

Although the work of the strategic initiative teams is at varying stages of completion, the following timeline depicts overall progress of the Creating Opportunities strategic initiative to date:



DBHDS executive leadership and System Leadership Council are reviewing each team's progress and will monitor the implementation of the strategic initiatives.

II. Behavioral Health Services and Supports

1. EMERGENCY RESPONSE

GOAL: STRENGTHEN THE RESPONSIVENESS OF THE EMERGENCY RESPONSE SYSTEM AND MAXIMIZE THE CONSISTENCY, AVAILABILITY, AND ACCESSIBILITY OF SERVICES FOR INDIVIDUALS IN CRISIS ACROSS VIRGINIA.

BACKGROUND/RATIONALE

- Persons with mental illness and substance use disorders continue to be involuntarily hospitalized and incarcerated in high numbers. Voluntary alternatives to hospital treatment and services to divert individuals from jail need to be improved.
- Virginians do not have access to a consistent basic array of emergency and crisis response services statewide, including crisis stabilization and jail diversion services.

- More consistent management of intensive services such as state hospital, local inpatient, and residential crisis programs is needed across regions to minimize use of these services and use them most efficiently and equitably.

IMPLEMENTATION ACTION STEPS

A. Enhance Statewide Emergency Response Services Capacity

- Conduct an on-line community services board/behavioral health authority (CSB) survey in March 2011 to identify the range of services available to adults in crisis, including:
    - Access to crisis response modalities;
    - Identification of the five most needed services
    - Access to peers or provision of peer support services to individuals in crisis;
    - Identification of non-crisis services or supports felt to be the most effective in preventing individuals from experiencing crises (those already receiving services and those who have not previously been seen by the CSB);
    - Identification of resources or services that have been most effective in diverting individuals in crisis from hospital-based inpatient psychiatric treatment; and
    - Degree to which individuals in crisis have an advance directive or similar crisis plan.
- Conduct a survey by the end of April 2011 of local hospitals on their experiences and views regarding their continuing roles in provision of emergency response services.
- Survey developed with the Virginia Hospital and Healthcare Association was disseminated for review by a small number of hospitals. (Completed)
- Use survey results to define emergency response baseline and priorities.
- Facilitate the establishment and consistent operation of crisis intervention services, through ongoing activities of the DBHDS crisis intervention specialist. This position was created by restructuring the responsibilities of a vacant DBHDS position.
- Determine resource requirements to expand emergency response services to bring all CSBs up to a baseline of services.
- Determine resource requirements to expand services that prevent or reduce the need for crisis response services.

B. Incorporate Peer Providers in Emergency Response Services

- Implement federal Substance Abuse and Mental Health Services Administration (SAMHSA) Practice *Guidelines: Core Elements for Response to Mental Health Crisis* systemwide through activities of the DBHDS crisis intervention specialist, including:
    - Development of a web-based recovery-based recovery training module for emergency services;
    - Provision of educational events systemwide on best practices in crisis stabilization, including the use of the practice guidelines; and
    - Provision of oversight and mentoring to support providers utilizing the guidelines.
- Increase utilization of recovery resources by providers of crisis services:
    - Provide education and support to crisis response systems on how to utilize peer support workers and access peer networks statewide.
    - Compile and disseminate materials for individuals and families in crisis, including:
        - What to do in a crisis, including crisis line telephone numbers,
        - Literature on the temporary detention order (TDO) process,

        - Peer and family support,
        - Literature on various mental illnesses, and
        - Post-crisis information (e.g., advance planning and wellness plans).
- Utilize experience of the Psychiatric Advance Directive Facilitation project underway at four CSBs to increase use of wellness recovery action plans and advance directives by consumers and staff in routine service delivery.

C. Enhance Criminal Justice/Behavioral Health Systems Collaboration

- Conduct an on-line survey of CSBs, local jails, and community corrections to be administered by May 2011 regarding criminal justice/behavioral health activity across the state, including resources and gaps.
- Support development of local Crisis Intervention Team (CIT) programs through activities of the DBHDS Cross-Systems Mapping Coordinator:
    - Determine resource requirements to expand CIT programs across the Commonwealth.
    - Identify potential resources, including federal SAMHSA and Bureau of Justice Assistance (BJA) Byrne grants administered directly from BJA or through the Department of Criminal Justice Services (DCJS) for continued CIT program development.
    - Determine resource requirements to support a pilot project that establishes police drop-off centers in three CSB service areas.
    - Utilize 40 hour CIT training model for law enforcement and first responders:
        - Support collaborative mental health and law enforcement faculty and practices,
        - Enhance train-the-trainer capability, and
        - Provide CIT dispatcher training for 100% of dispatchers.
    - Encourage emergency services workers to participate in CIT law enforcement ride-along as part of base training.
    - Develop a data-based system in collaboration with CSBs and criminal justice system agencies for measuring Core Elements outcomes of CIT programs by November 2011.
- Support continued use of Sequential Intercept Model and Cross Systems Mapping workshops:
    - Develop plans to seek renewal of Executive Order 98 (2009) by June 2011.
        - This Executive Order directs the Offices of the Secretaries of Health and Human Resources and Public Safety to lead the Commonwealth Consortium for Mental Health/Criminal Justice Transformation, with the dual purpose of preventing unnecessary involvement of persons with mental illness in the Virginia criminal justice system and promoting public safety by improving access to needed mental health treatment for persons with mental illness for whom arrest and incarceration cannot be prevented.
    - Report on the current status of gaps, resources, and priorities developed through the 19 completed Cross-Systems Mapping activities by mid-April 2011.
        - Update report quarterly as other communities receive mapping workshops.
    - Implement the comprehensive outcomes reporting process for the Cross-System Mapping Initiative.

- Prepare Cross Systems Mapping Initiative interim and final reports between January 2012 and January 2013.

- Facilitate, in collaboration with VOCAL, NAMI-VA, and other consumer, family, and advocacy organizations, the involvement of peers with a lived criminal justice experience in supporting individuals with mental illness throughout the criminal justice continuum by:
  - Providing training that specifically targets law enforcement and consumers as part of the Joint NAMI-Virginia CIT Coalition Conference on September 11-14, 2011 (Up to 180 Virginia stakeholder scholarships will be available through a contract with National Association of State Mental Health Program Directors and NAMI-VA);
  - Examining evidence-based programs and recommend curricula and programs by the end of June 2011;
  - Identifying costs and potential resources to provide training identified in the recommended curricula by the end of June 2012; and
  - Exploring the feasibility of enabling peers with lived criminal justice experience to provide evidence-based programs to incarcerated individuals by the end of June 2012.

- Identify curricula components by July 2012 for providing training on the following topics to court personnel (judiciary, prosecutors, defense bar and other attorneys, clerks and bailiffs), probation and parole, community corrections, jail and other corrections staff, and emergency services workers:
  - Basic mental illness,
  - Access to services,
  - Basic de-escalation,
  - Civil commitment procedures and impact on individuals,
  - Competency restoration, and
  - Insanity defense procedures and their impact.

2. PEER SERVICES AND SUPPORTS

GOAL: ***DEVELOP INFRASTRUCTURE TO INCREASE PEERS IN DIRECT SERVICE ROLES AND EXPAND RECOVERY SUPPORT SERVICES.***

BACKGROUND/RATIONALE

- Peer support is known to be an important factor in the recovery process for many individuals with mental health, substance use, or co-occurring disorders.
- The 2010 Recovery Oriented System Indicator (ROSI) survey of 3,559 of the adult CSB mental health service recipients reported that 54% of respondents scored their system's recovery orientation above average and 46% below average. The item respondents said made the most difference was the availability of peer advocates to turn to when they were needed. Respondents reported that only 47% have a consumer peer advocate to turn to when they needed one.

IMPLEMENTATION ACTION STEPS

A. Establish a Peer Support Provider Certification Program

- Review other states' approaches for providing mental health, substance abuse or combined mental health/substance abuse peer support services, including peer support certification by the end of April 2011.

- Survey and describe existing CSB and state facility peer support services by the end of April 2011.
- Develop a background paper by mid-April 2011 that includes:
    - Statement of the value and importance of peer support services:
        - Rationale - why peer support is a critical service clinically and programmatically;
        - Summary of Virginia and other states' mental health, substance abuse or combined mental health/substance abuse peer support programs, including how they are funded; and
        - Cost-effectiveness of peer support services;
    - Recommended components of the peer support provider certification program:
        - Peer support core competencies;
        - Definitions regarding what a peer provider is/does/roles;
        - Curriculum components used by other states;
        - Training to be provided through a free market approach; and
        - How to implement certification process;
    - Projected resource requirements to establish and maintain a peer certification program, to include training and DBHDS administration of the certification process; and
    - Projected resource requirements to expand peer support services.
- Implement certification process by July 2012, contingent on resource availability.

B. Establish DBHDS Peer Services and Supports Office

- Review other states' mental health, substance abuse or combined mental health/ substance abuse peer services and supports offices, including responsibilities, staffing, and funding by the end of April 2011.
- Collect information on mental health, substance abuse or combined mental health/substance abuse peer services and supports offices by the end of April 2011.
- Develop a background paper by mid-April 2011 that includes:
    - Statement of the value and importance of peer support services, including a rationale and summary of other states' mental health, substance abuse or combined mental health/substance abuse peer services and supports offices;
    - Recommended components of the DBHDS Peer Services and Support Office:
        - Office responsibilities and functions;
        - Mechanism for office interface with the peer community; and
        - Staffing and organizational configuration; and
    - Estimated resource requirements for a DBHDS Peer Services and Supports Office.
- Establish Peer Services and Supports Office by July 2012, contingent on resource availability.

C. Establish Peer Support Services as a Covered State Medical Assistance Plan Service

- Work with DMAS to develop Medicaid Peer Support Services regulations by December 2012 that include:
    - Peer support services definition,
    - Program and provider requirements, and
    - Rates.

3. SUBSTANCE ABUSE TREATMENT SERVICES

GOAL: ENHANCE ACCESS TO A CONSISTENT ARRAY OF SUBSTANCE ABUSE TREATMENT SERVICES ACROSS VIRGINIA.

BACKGROUND/RATIONALE

- Untreated substance use disorders costs the Commonwealth of Virginia millions of dollars in cost-shifting to the criminal justice system, the health care system, and lost productivity, not to mention the human suffering and effects on family and friends. A 2008 study conducted by the Joint Legislative Audit and Review Commission (JLARC), *Mitigating the Cost of Substance Abuse in Virginia,* conservatively estimated the cost in 2006 dollars to be $613 million to the criminal justice system alone.
- The 2008 National Survey of Drug Use and Health (NSDUH), conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA), estimates that 23.66% of Virginians over 12 engaged in binge drinking (5 or more drinks in one occasion), and 590,000 individuals met clinical requirements for abuse or dependence of either alcohol or illicit drugs.
- The Virginia Department of Health Office of the Chief Medical Examiner reported 331 deaths from prescription drug poisoning in 2008, most of which were narcotic pain medication, a trend that has been increasing for several years.
- Co-occurring mental illness and substance use is common: 35% of people with serious mental illness using alcohol or other drugs in a way that compromises stable recovery, and 19% of persons with alcohol abuse or dependence meet criteria for a mental illness.
- Virginia ranks low in support for community drug and alcohol treatment. A study by the National Center on Addiction and Substance Abuse at Columbia University (CASA) of 47 states and territories ranked Virginia 36th in per capita spending on substance abuse prevention, treatment and research ($5.65 per capita), behind other southeastern states such as Georgia, Louisiana, Mississippi, and Kentucky.
- Several Virginia-specific studies have identified the lack of access to a consistent array of services across the state. A 2006 report by the Office of the Inspector General (OIG) found waiting times averaging 26 days to receive services at CSBs and also found notable gaps in the array of treatment services. The 2008 JLARC study determined that substance abuse treatment services provided by CSBs are effective and have the impact of lowering other costs to the Commonwealth; however, services are not widely accessible, especially to the majority of offenders returning to the community.
- Substance misuse and addiction commonly lead to crimes and criminalization of addiction. 70% of Virginias' incarcerated populations have substance abuse issues that, if not addressed, considerably increase the risk of recidivism.
- Governor McDonnell's Virginia Prisoner and Juvenile Re-entry Council has recommended adoption of evidence-based treatment models at prisons and jails, and in the community, with improved coordination and continuity for the 13,000 inmates who return to Virginia communities each year.

IMPLEMENTATION ACTION STEPS

A. Develop a Comprehensive Proposal to Expand Evidence-Based Substance Abuse Treatment Services Across the Commonwealth

- Identify gaps in the array of evidence-based substance abuse treatment services.

- Review 2010 fourth quarter performance data submitted by each CSB, analyze regionally, and identify services gaps. (Completed)
- Collect detailed information about services currently provided to individuals, including people with co-occurring mental illness and substance use disorders; service gaps and priorities for services; barriers to service implementation and use of Medicaid; and community environmental influence on service needs.
  - Survey CSB executive directors and SA managers. (Completed)
  - Meet with representatives of the Virginia Association of Community Services Boards (VACSB) SA Services Council. (Completed)
- Complete a review of services available from CSBs and private providers (for low income persons), including an identification of service gaps, needs, and priorities for cost-effective treatment completed in the interview process (Completed)
- Review and summarize other existing data that identifies treatment services needs (OIG SA Adult Outpatient Study, Project TREAT documents, Children's Study). (Completed)
- Define the array of substance abuse services required for system integrity. (Completed)
- Establish priorities for development of cost-effective substance abuse services, in collaboration with the Creating Opportunities Substance Abuse Treatment Services Implementation Team (SATSIT). (Completed)

- Develop a comprehensive plan to fill service gaps and provide a foundation of core services to meet substance use disorder needs in each community, with specific action steps and resources needed to implement this plan over a period of years by May 2011. Services gaps have been identified and an effort is underway to determine resource requirements to expand each of the following services:
  - Substance abuse services, including medication assisted treatment, intensive outpatient services, case management, detoxification beds, and residential treatment for pregnant women and women with dependent children and enhanced uniform screening and assessment;
  - Community treatment and support services tailored to divert young (juvenile and young adult) nonviolent offenders from incarceration, using an approach similar to the Substance Abuse Rehabilitation and Education (SABRE) program initiated during the Gilmore Administration;
  - Additional Project Link sites that provide intensive, coordinated interagency care for pregnant and post-partum women who are using drugs;
  - Substance abuse peer recovery programs that provide group support, housing and employment assistance, day activity, and linkage to community resources; and
  - Structured, safe, sober living environments for adults who are actively engaged in treatment as a "step down" from detoxification or other residential services.
- Explore the feasibility of implementing the Network to Improve Addiction Treatment (NIATx) systems engineering model to improve the efficient use of resources and highlight operational policies and procedures that hamper successful treatment. NIATx was originally launched under the auspices of the Robert Wood Johnson Foundation and SAMHSA as a disciplined approach to rapid systems change that can be applied to issues affecting treatment outcomes such as reducing waiting time to access treatment, improving access to evidence-based treatment, and improving retention in treatment.

- Assess the extent to which CSBs have the capability to provide integrated substance abuse and mental health assessment and treatment for individuals with co-occurring disorders and provide technical assistance and training to enhance that capability.
- Develop a proposal to revise the taxonomy of substance abuse adult and adolescent services for the publicly funded services system to reflect placement criteria from the American Society of Addiction Medicine by May 2011.
- Identify workforce development needs by June 2011.
- Identify systemic technical assistance needs by June 2011.

B. Expand Partnerships with the Criminal Justice System to Include Substance Abuse Treatment in Jails and in Re-entry Programs for Offenders

- Develop a plan with the SATSIT by June 2011 for providing substance abuse supports and clinical services, including criminal justice-specific evidence-based practices and programs, when needed, to individuals in the Commonwealth's criminal just system.
    - Review components of successful programs such as Boaz & Ruth, a private non-profit that supports people coming out of prison by providing skill training related to furniture repair and refinishing and retail operations.
    - Collaborate with Community Corrections Boards on re-entry issues.
    - Explore service approaches for individuals involved in the criminal justice system such as a new kind of case managers to whom individuals could report instead of going to jail.
    - Identify partnership opportunities and requirements for successful implementation (e.g. workforce development, funding opportunities, and strategies) with DOC and DJJ.

4. STATE HOSPITAL EFFECTIVENESS AND EFFICIENCY

GOAL: **REVIEW AND DEVELOP STRATEGIES TO ENHANCE THE EFFECTIVENESS AND EFFICIENCY OF STATE HOSPITAL SERVICES.**

BACKGROUND/RATIONALE

- The roles of state hospitals and private hospitals have continued to evolve as Virginia works to implement state policy promoting community-based care. Access to and discharge of individuals from state hospitals and publically-funded care provided by private psychiatric hospitals is now managed by regional consortia of CSBs and other stakeholders in the jurisdictions served by the state hospitals. Active regional management is challenged by the loss of private psychiatric beds and by regional differences in needs, resources, and service availability.
- The allocation of state hospital beds and services for forensic populations currently exceeds 38% of capacity. The rate at which forensic referrals are coming to the state hospital system, especially persons adjudicated Not Guilty by Reason of Insanity (NGRI), and the length of stay of these persons is leading to a situation in which available bed space is increasingly dedicated to persons under forensic status. These persons typically have longer lengths of stay than civil patients, partly due to the need to satisfy legal as well as clinical needs. Without developing such community-focused forensic services as evaluations, restoration of competency, and treatment for persons found NGRI, the proportion of beds and services for the civil population will continue to reduce.
- Many persons referred to state hospitals for pretrial evaluation and treatment on an inpatient basis do not require the level of care provided in state hospitals and could be managed on an

outpatient basis. However, the quality of outpatient evaluations is not always desirable due to lack of ongoing training/oversight of community evaluators, resulting in new insanity acquittals of persons who do not always meet criteria, and whose hospital stays are lengthy and costly.

- Virginia serves elderly persons with psychiatric needs in its state hospitals (representing 30% of total hospital capacity) rather than in the community. This rate is exceeded by only four other states. Alternatives can be made available in the private provider community.
- Virginians from all parts of the state should be able to expect comparable levels and goals of treatment effectiveness and efficiency from all state hospitals. Currently, state hospital services, populations, policies, procedures, and practices vary significantly. There also are considerable differences in hospital staffing patterns, facility organizational structures, and staff allocations. While much of this variability may be functionally or population appropriate and regionally-relevant some may not be, resulting in needless overlap or gaps, redundant and inconsistent activities, and inefficiencies on a system-wide basis.
- There are limited and inconsistent oversight and requirements for accountability of state hospital programs, policies, and practices by the DBHDS central office. State hospitals function with a high degree of independence from one another and from central office, with limited sharing of their successes, problems, and resources. Results of audits by national and state oversight, accrediting, and funding authorities have shown some excellent performances, along with inconsistencies, problems, and gaps in compliance among the hospitals.

IMPLEMENTATION ACTION STEPS

A. Implement State Facility Annual Consultation Audit (ACA) Process

Phase I: State Hospital ACA Implementation – 2011

Phase II: Training Center ACA Implementation – Begin 2012

- Finalize state hospital ACA quality review instrument. (Completed)
    - Team review and recommendations on the proposed instrument.
    - Identify facility-specific data and documentation requirements, including materials to be provided by facilities in advance.
    - Conduct small internal test of instrument implementation at volunteer hospital.
    - Revise instrument following test visits.
- Determine state hospital ACA review team size and composition. (Completed)
        - DBHDS membership:
            - Central office executive leadership involvement,
            - State hospital director participation,
            - Central office program staff, and
            - State hospital clinical staff.
        - External reviewers, to include consumers and CSB representatives.
    - Revise team size and composition based on pilot experience.
- Define process for identifying candidates for teams and selecting team members.
- Pilot ACA quality review instrument and process at volunteer hospital to assess the following: (Completed)
    - Time required to implement instrument;
    - Reasonableness of facility documentation requirements; and
    - Central office process administration requirements.
- Establish orientation/training requirements for ACA review team members.

- Designate responsible CO staff to coordinate ACA process administration and follow-up.
- Establish first year ACA quality review schedule by April 2011.
- Monitor process ACA administration and recommendation follow-up.
- Establish mechanism to address systemic issues identified in ACA quality reviews, e.g., interface with the DBHDS Division of Quality Management and Development.
- Develop, based on survey results, internal operating policies and procedures (DIs) and recommendations regarding best practices, standardization, and duplication reduction.
    - Develop DI on the state facility ACA quality review process.

B. Develop a Comprehensive Proposal to Reduce or Divert Forensic Admissions from State Hospitals and Increase Conditional Releases and Discharges to the Community

- Establish a task force by May 2011 to examine NGRI statutes (revocation of conditional release) and forensic evaluation oversight to identify any needed changes.
- Evaluate the size and usage of the maximum security unit at Central State Hospital by the end of December 2011.
- Update the DBHDS MOU with DOC regarding management of mandatory parolee admissions by May 2011.
- Develop Department policy on admission to the Central State Hospital Forensic Unit for emergency treatment/competency evaluation by June 2011.
- Develop a structured restoration treatment protocol for CSBs and state hospitals.
- Implement changes in DBHDS policy regarding management of NGRI acquitees.
- Determine resource requirements to expand outpatient restoration services and enhance the Commonwealth's ability to provide outpatient forensic evaluations.
- Expand community training on forensic issues.
- Improve forensic data availability in the DBHDS Forensic Information System (FIMS).

C. Develop a Comprehensive Proposal to Reduce or Divert Older Adult Admissions from State Hospitals and Increase Discharges to the Community

- Identify barriers to providing services to older adults with behavioral and psychiatric needs in their home communities by April 2011.
- Recommend best practices and programs to increase community-based service opportunities and provide an appropriate and limited role for state hospitals by May 2011.

D. Establish Staffing Ratios for Each State Hospital

- Complete a comprehensive review of state hospital staffing allocations.

E. Define the Future Roles and Core Functions of State Hospitals

- Complete a review the historic roles of state hospitals and utilization trends by July 2011.
- Describe current facility role variations and factors contributing to this variation by August 2011.
- Complete an assessment of the future need for state hospital services by September 2011:
    - Describe issues or challenges that would affect future service delivery.
    - Identify populations that should be the future focus of state hospital services in the future.
- Provide recommendations to the Commissioner by September 2011 regarding the:

- Future role and core functions of state hospitals;
- Opportunities for public and private development of specialized community-based services for specific populations (e.g., forensic, elderly) whose care has historically been provided in hospital settings, and
- Best practices for regional management of inpatient resources.

5. Child and Adolescent Mental Health Services Plan

Goal: Develop and implement a comprehensive plan for child and adolescent mental health services.

Background/Rationale

- The 2010 General Assembly tasked DBHDS with establishing a comprehensive plan to "identify concrete steps to provide children's mental health services, both inpatient and community-based, as close to children's homes as possible."
- The interim report found that a comprehensive service array is not consistently available in all areas of the state. Further, even when services are available there is not sufficient capacity.

Implementation Action Steps

A. Submit the Interim Report to the General Assembly (Completed)

B. Assess the Current Availability of Child and Adolescent Mental Health Services Across the Commonwealth

- Complete the analysis of data obtained through a survey of CSBs by April 2011, to include the:
  - Current status of services in the comprehensive array that is available in each CSB;
  - Capacity of each available service; and
  - Availability of services offered by the private sector.

C. Project Resources Required to Fill Child and Adolescent Mental Health Services Gaps

- Identify base service requirements and services gaps by the end of April 2011.
- Develop estimates of the cost of providing each base service in the comprehensive service array in each CSB.
- Determine resource requirements to fill in these gaps by the end of April 2011.

D. Submit the 2011 Final Report to the General Assembly a Phased Plan of Needed Investments to Improve Accessibility to Child and Adolescent Mental Health Services Over the Next Several Biennia by November 2011.

III. Developmental Services and Supports

1. Developmental Services and Supports Capacity

Goal: Build community services and supports capacity that will enable individuals who need developmental services and supports, including those with multiple disabilities, to live a life that is fully integrated in the community.

Background/Rationale

- Virginia is currently faced with a waiting list of over 5,000 individuals for the ID and the Families with Developmental Disabilities Supports (IFDDS) waivers. The General Assembly

has recognized the waiting list issue and has expressed its desire through public policy statements to eliminate the waiting list by 2018.

- Demand for adult developmental services will escalate over the next five years as the rapidly growing number of children identified with autism or other developmental disabilities that are now receiving special education services leave schools systems.
- There continues to be an imbalance in Virginia's distribution of resources available for developmental services due to a dual system that continues to support both institutional and community models of support. A new way of supporting individuals must be developed if Virginia is to adequately meet future demand for services and supports.
- In its report on the investigation of the Central Virginia Training Center (CVTC), the Department of Justice (DOJ) has made it clear that it is expecting to see more aggressive initiatives to insure that adequate community support services are made available for individuals as real alternatives to institutional placements and that segregated institutions do not play significant roles in the services and support systems for the Commonwealth.

IMPLEMENTATION ACTION STEPS

A. Transform to a Community-Based System of Developmental Services and Supports

- Improve services and supports coordination and planning in provider community.
    - Establish a system to use information about identified services and supports needs of individuals in training centers and on current wait lists to build community capacity.
- Incorporate the work of the Creating Opportunities Developmental Services Capacity Expansion Implementation Team into Virginia's plan for allocating the $30 million Trust Fund pursuant to §37.2-319.
- Significantly expand waiver capacity to address both individuals in training centers and those on the waitlist in the community.
- Work with the Department of Medical Assistance Services (DMAS) to amend existing waivers and create new waivers by Fall 2011. It is the recommendation of the Creating Opportunities Developmental Services Capacity Expansion Implementation Team that the new waivers will include a:
    - Supports waiver (with annual dollar cap) to maintain individuals in their homes, and
    - Comprehensive waiver to assist those with the most complex needs.
- Work with DMAS to revise current waiver rate structure, particularly for residential services.
    - Initiate a waiver rate study, at least for residential services by Spring 2011.
    - Develop rate system based on model of services, level of severity, and level of expertise needed.
    - Reduce documentation requirements.
    - Ensure rate structure incentivizes best practice such as use of smaller homes, Money Follows the Person (MFP), and supported employment.
- Develop a budget initiative to support development of community-based developmental services and supports.
    - The DOJ/DBHDS agreement will dictate much of how and when many of the community transformation and training center restructuring changes will occur.
- Expand access to community-based services and supports:

- Develop specialized medical, dental, behavioral, and other clinical services in the community and expand access to "non-specialized" community practitioners.
- Establish a crisis management system in every community.
- Develop community respite alternatives to training centers.

- Improve quality assurance and oversight resources to enable:
  - Identification of deficiencies;
  - Electronic client-level tracking of incidents and systemic analysis of trends and patterns; and
  - Follow- up to assure corrective actions are implemented.

2. AUTISM/DEVELOPMENTAL DISABILITIES INTERAGENCY PLANNING

GOAL: PROVIDE LEADERSHIP AND PARTICIPATE IN INTERAGENCY PLANNING CURRENTLY UNDERWAY TO IDENTIFY RESPONSIBILITY AT THE STATE LEVEL FOR COORDINATING AND PROVIDING SERVICES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES INCLUDING AUTISM SPECTRUM DISORDERS.

BACKGROUND/RATIONALE

- Actions proposed to implement the Creating Opportunities Developmental Services Capacity Development strategic initiative will include and benefit individuals with autism spectrum disorders (ASD) and other developmental disabilities.
- In addition, the recently completed *"Assessment of Services for Virginians with Autism Spectrum Disorders"* provides the General Assembly a detailed action plan for coordinating and funding ASD and developmental disability services in Virginia.

IMPLEMENTATION ACTION STEPS

A. Define DBHDS and Developmental Services System Responsibilities for ASD and Developmental Disabilities

- Develop recommendations for consideration by the 2012 General Assembly to clearly define CSB responsibilities for serving these populations and lay the groundwork for future coordinated efforts between CSBs, DMAS, Department of Education (DOE), Department of Rehabilitative Services (DRS), school systems, and other partners to expand the type and availability of services for individuals with developmental disabilities.
- Create a memorandum of understanding (MOU) with the following agencies that designates DBHDS as the coordination agency for developmental disabilities, establishes a data collection workgroup to document interagency needs, and provides a structure for discussing interagency collaboration challenges and opportunities and sharing quarterly updates on activities pertaining to developmental disabilities:
  a. Department of Education,
  b. Department of Rehabilitative Services,
  c. Department of Health,
  d. Department of Social Services, and
  e. Department of Criminal Justice Services.

  DBHDS currently has a MOU with DMAS.

B. Enhance Statewide ASD and Developmental Disabilities Services and Supports Capacity

- Develop an implementation plan to advance the recommendations in the Joint Legislative Audit and Review Commission (JLARC) *"Assessment of Services for Virginians with Autism Spectrum Disorders"* report, including strategies to:
    - Close the gap between early diagnosis and intervention for individuals with ASD.
        - Seek grant funding to establish a statewide public service campaign regarding early detection and screening for ASD.
        - Expand and develop Communities of Practice in Autism (CoPA) in order to develop skills and enhance service delivery planning and implementation through the Part C Early Intervention program. Six CoPAs have been established in Virginia to date.
        - Report on the impact of the recently passed "Autism Insurance Mandate" on the Part C program.
        - Develop a report on the costs and benefits of providing more specialized programs for children with or suspected of having ASD, including more intense services, staffing and instruction.
    - Provide innovative employment training for individuals with ASD and developmental disabilities.
        - Increase employment skills and opportunities for adults with ASD who are no longer in the school system, through a dual phase Project SEARCH model. This evidence-based employment model has proven to be an effective way to reach out to the business community and provide integrated internships and employment with site training and intensive supports.
        - Conduct two trainings for service providers and families per region using the Virginia Autism Council's "Adult Strategies for those with Autism" materials.
- Determine resource requirements to provide the following ASD and developmental disabilities services and supports, identified in the JLARC report:
    - Reestablishment of Family Support funding for CSBs;
    - Expansion of the CoPA initiative to develop skills and enhance service delivery planning and implementation;
    - Funding Project SEARCH model project to increase work opportunities for individuals who are no longer school age;
    - Expansion of DRS case services to respond to increasing demands for ASD services; and
    - Increase DBHDS staff with expertise in ASD and developmental disabilities to assist in implementing JLARC report recommendations.
- Provide trainings for the CSB Child and Family Services providers on how to interact with and address the needs of the growing ASD population, access services, and advocate with families.
- Provide interactive trainings to all training center direct support staff concerning basic interactions and understanding of individuals with ASD.

IV. Systemwide Strategic Initiatives

1. HOUSING

GOAL: ADDRESS HOUSING NEEDS FOR INDIVIDUALS WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS AND THOSE WITH DEVELOPMENTAL DISABILITIES.

BACKGROUND/RATIONALE

- As noted in President Bush's 2003 *New Freedom Commission on Mental Health* report, *"the shortage of affordable housing and accompanying support services causes people with serious mental illnesses to cycle among jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or to live in seriously substandard housing."*
- Safe, decent, and affordable housing is essential to recovery, and housing stability is correlated to lower rates of incarceration and costly hospital utilization (e.g., see Gilmer et al, in the Archives of General Psychiatry, 2010; 67(6):645-652; "*Reductions in costs of inpatient/emergency and justice system services offset 82% of the cost of supportive stable housing and mental health services for homeless adults with mental illness"*).
- The Supreme Court's decision in *Olmstead v. L.C*, 527 U.S. 581 (1999) held that the unjustified institutionalization of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act (ADA). A United States District Court 2009 ruling in Disability Advocates, Inc. (DAI) v Governor Paterson, et al, found that large adult homes "are not the most integrated setting appropriate to the needs of DAI's constituents, especially compared to supported housing, in which individuals with mental illness live in apartments and receive flexible support services as needed" and the State's mental health system's reliance on them is in violation of the Olmstead integration mandate.
- The Medicaid ID and IFDDS waivers do not pay for housing, only services. For individuals with intellectual disability who are served in training centers, Medicaid pays for room and board.
- Between January and April 2010, 3,559 adults receiving CSB mental health services completed the Recovery Oriented System Indicators Survey (ROSI) survey, which measured their recovery experience. Only 58% of the respondents said they had housing that they could afford.
- It is generally held that individuals should not spend more than 30% of their monthly income on housing. Monthly Supplemental Security Income (SSI) payments for an individual are $674 in Virginia while the average Fair Market Rent for a one-bedroom unit is $887. Auxiliary Grants subsidize housing for individuals receiving SSI, but are limited to Assisted Living Facilities and Adult Foster Care homes and cannot be used more flexibly in other housing arrangements.

IMPLEMENTATION ACTION STEPS

A. Support Implementation of the Governor's Housing Initiative Recommendations

- Participate in cross secretarial and interagency activities to leverage state and federal funds for special needs housing, establish and align state priorities and program resources, support inter-agency and inter-secretarial collaboration, expand access to non-institutional community housing options, and address local barriers to affordable housing.
- Support the work of the Governor's Homeless Outcomes Workgroup to expand permanent supportive housing, prevent homelessness and support rapid re-housing, increase statewide data collection and coordination, increase access to behavioral health services, and strengthen discharge policies and protocols.
- Expand the capacity of public and non-profit homeless services providers to connect individuals receiving services to SSI/SSDI benefits.
    - Establish, through a contract with the VCU School of Social Work, a state coordinator to implement the SSI Outreach and Recovery (SOAR) evidence-based practice and provide technical assistance and training on SOAR to homeless services providers.
- Determine resource requirements to create additional Housing First Projects.

B. Establish and Implement Clear Housing Stability Expectations for CSBs

- Work through the DBHDS/CSB Partnership Agreement to include the goal of housing stability as a systemic performance measure.
- Include affirmation of CSB responsibilities related to housing stability in the DBHDS Performance Contract, to include:
    - Maximizing federal, state, and local resources for the development of and access to affordable housing and appropriate supports through joint written agreements with public housing agencies, where they exist, and work with planning district commissions, local governments, private developers, and other stakeholders;
    - Reporting information to DBHDS on current CSB housing resources and partnerships, resource sharing, and capacity building to permanently house CSB-eligible individuals who would otherwise be homeless; and
    - Monitoring and reporting to DBHDS on key housing outcome indicators.
- Collect data necessary to track housing stability.
    - Work with CSBs to develop a mechanism to report housing-status change information monthly for individuals receiving CSB case management services and analyze their length of housing tenure and frequency of moves.
    - Develop benchmarks and goals for housing stability by subpopulations.

C. Establish and Implement Policy of the Commonwealth That Community-Based Housing Options for People with Disabilities Must be Affordable, Accessible and Reflect Virginia's "Person-Centered" Vision

- Work with the Department of Housing and Community Development (DHCD), Virginia Housing Development Authority (VHDA) and DMAS to develop a state policy statement and associated cost estimates for implementation by November 2011.
- Develop a plan with DHCD, VHDA and DMAS to expand critically needed community housing options for people with intellectual and related developmental disabilities, prioritize state agency investments and align federal, state, local and private investment resources to significantly increase the development of integrated community housing.
- Adopt an updated Memorandum of Understanding (MOU) among DBHDS, VHDA and DHCD by Fall 2011 that*:*
    - Formalizes a working relationship between the DBHDS housing specialist and key staff of the other agencies and provision of a permanent state resource for education and training to CSBs and others on how to connect housing and the needs of people with intellectual and related developmental disabilities.

D. Develop or Provide Access to Affordable Housing with Appropriate Supports for Individuals with Mental Health, Substance Use, or Co-Occurring Disorders

- Provide, through the contract with the VCU School of Social Work, four regional trainings on SAMHSA's Supportive Housing "toolkit" in Spring 2011.
- Provide additional consultation on the development of supportive housing through a VCU School of Social Work subcontract with a Virginia-based organization with supportive housing expertise.
- Establish and sustain regional planning and collaborative coalitions of CSBs, public housing authorities (PHAs), planning district commissions, and local housing organizations that implement the supportive housing model.
    - DBHDS housing specialist for behavioral health and developmental services will:

- Develop strategies to implement the State Board Policy on Housing Supports, including promotion of consumer preferences;
- Promote current effective CSB/PHA partnerships, including the Harrisonburg and Hampton PHA initiatives;
- Review approaches for leveraging housing resources used in other states such as the Tennessee Creating Homes Initiative;
- Identify and work with housing "champions" among CSB leadership to promote the DBHDS policy statement that housing is essential to treatment and recovery and CSB responsibility should be to assure that appropriate housing is available; and
- Provide ongoing consultation and technical assistance to CSB and other public and non-profit providers on how to leverage housing resources and implement evidence-based supportive housing practice models.

E. Establish a Community Living Supplement Program for Room and Board to Support the Choice of Community Housing for Individuals Receiving Developmental Services

- Determine resource requirements to provide a community living supplement for individuals receiving developmental services by August 2012.

F. Explore the Development of a Centers for Medicare and Medicaid (CMS) Demonstration Waiver to Provide Individualized Resource Allocation that Permits "Decoupling" of Developmental Service Provision and Housing

- Develop a policy paper by May 2011 that describes issues and challenges associated with the current waivers that limit individuals' ability to live in the community in non-ICF-settings.
- Convene a multi-agency workgroup, including housing and local agencies, DMAS, Virginia Board for People with Disabilities (VBPD), and CSBs, to develop a concept proposal for "decoupling" service provision and housing.
    - Examine the potential use of Trust Fund dollars to support housing allocations that are separate from service provision.
    - Explore the potential certification of housing brokers.
- Develop and submit a demonstration waiver package to DMAS:
    - Receive approval from the Secretary of Health and Human Resources to apply for demonstration waiver.
    - Work with DMAS and CMS beginning in the Spring 2011 to design the waiver package.
    - Complete development and submit demonstration waiver package to CMS for implementation.
- Determine resource requirements to provide housing grants and other related costs as a component of the demonstration waiver by Fall 2011.
- Target demonstration waiver to a specific training center to transition residents into the community.
- Implement a SIS-guided system of individual resource allocation.

G. Explore the Potential Extension of the MFP Program to Individuals with Behavioral Health Concerns Who Are Transitioning from State Hospitals

- Continue dialogue and planning efforts with DMAS.

2. EMPLOYMENT

GOAL: CREATE EMPLOYMENT OPPORTUNITIES FOR INDIVIDUALS WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS AND THOSE WITH DEVELOPMENTAL DISABILITIES.

BACKGROUND/RATIONALE

- People who are employed contribute to the economy and improve their sense of self worth. There are interventions that have been proven to help adults with serious mental illness (SMI) transition from income subsidies to successful competitive employment, but as President Bush's *New Freedom Commission on Mental Health* (2003) reported, "Disturbingly, most vocational rehabilitation services are ineffective for the small proportion of people with mental illnesses who manage to get them."
- The Surgeon General reported in 1999 that unemployment rates among adults with SMI run as high as 90%. Today, CSBs report full or part-time employment rates of only 14% among adult mental health service recipients with SMI, 32% among adult substance abuse service recipients, and 16% among adult developmental services recipients. These high unemployment rates occur despite surveys that show the majority of adults with SMI want to work. Persons with intellectual disability are more likely to be unemployed than are persons with other disabilities.
- Adults with SMI make up the single largest diagnostic group (35%) on the Supplemental Security Income (SSI) rolls and over one quarter (28%) of all Social Security Disability Income (SSDI) recipients.
- A significant portion of special education students and families believe that if they work, they will lose their SSI benefits. Also, there is a significant lack of awareness of work incentives under SSA for SSI or SSDI recipients. Navigation through the work incentives and benefits available through SSA is laborious and very difficult to conquer in isolation.
- Most employees with intellectual disability need some type of long-term or intermittent employment support. In addition, many individuals with intellectual disability are not served by the Department of Rehabilitative Services (DRS) because they are considered DRS ineligible or not DRS-ready. The return on investment in long term employment supports for individuals with intellectual or developmental disabilities is for every one dollar spent on services three dollars in income is generated.
- The 2010 Recovery Oriented System Indicator (ROSI) survey of 3,559 adult CSB mental health service recipients measured perceptions of how well the service system supported them in recovery. Help with getting and keeping employment was found to be one of the most significant factors in whether respondents scored the system as having a recovery orientation.

IMPLEMENTATION ACTION STEPS

A. Establish Policy for the Commonwealth Regarding Employment for Individuals with Mental Health or Substance Use Disorders or Developmental Disabilities

- Develop an Employment First policy statement that emphasizes integrated and supported employment over sheltered employment with sub-minimum wages or non-work day activities in the developmental and behavioral health services system the Commonwealth and explore the appropriateness of an Executive Order for this policy.
- Conduct an "Employment First" Summit with leadership-level participation from each department with investments in employment for people with disabilities by early Fall 2011.
    - Work with businesses/business organizations to help sponsor summit.
    - Conduct workshops to develop cross-agency implementation strategies.

- Develop a new State Board policy that establishes outcome expectations that promote employment opportunities for individuals with mental health or substance use disorders or developmental disabilities.

B. Implement Regional "Employment First" Roll-Out and Regional Trainings for Employers of Individuals Receiving Developmental Services in All Areas of the State

- Conduct a statewide awareness and education campaign.
- Use trainings to expose employers to new innovative employment models and train them in how to assist challenging individuals.

C. Implement Clear Employment Outcome Expectations in the DBHDS Performance Contract with CSBs for Individuals Receiving Behavioral Health Services

- Work through the DBHDS/CSB Partnership Agreement to include the goal of gaining or maintaining meaningful employment as a desired outcome for adults receiving services.
- Include affirmation of CSB responsibilities related to provision of employment opportunities, to include:
    - Employment services availability and streamlined employment service delivery by implementing integrated treatment/support teams through joint written agreements with regional DRS offices and work with Employment Services Organizations (ESOs), where they exist;
    - Inclusion of consumer interest in employment in quarterly assessments and quick engagement in employment services if interest exists; and
    - Monitoring and reporting to DBHDS key employment outcome indicators established in the employment policy.
- Establish a mechanism to monitor change in CSB service recipients' employment status.
    - Negotiate interagency agreements to match Virginia Employment Commission (VEC) and DRS data to CSB service records, using hashed SSNs to protect confidentiality, in order to monitor the employment status of individuals receiving CSB services.

D. Establish and Sustain Real Work Opportunities for Individuals with Mental Health, Substance Use, or Co-occurring Disorders

- Partner with DRS, DMAS, CSBs, and others to develop employment services that implement supported employment evidence-based practice models:
    - DBHDS employment specialist for behavioral health and developmental services will:
        - Promote implementation of supported employment evidence-based practice models with DRS staff and vendors, to implement and fund supported employment services;
        - Support establishment by CSBs, DRS, and ESOs of integrated supported employment teams; and
        - Work with the VCU Work Incentive Planning and Assistance National Training Center and its community work incentives coordinators to ensure that qualified, trained work-related incentives/benefits counselors and access to the VCU Employment Support Institute's WorkWORLD^{TM} software are available statewide.
- Determine resource requirements to expand supportive employment services statewide and provide additional training on benefits counseling.

E. Expand Long-Term Employment Support Services (LTESS)

- Work with DRS to expand LTESS.

F. Use VaACCESS Funding to Train and Certify CSB and DD Waiver Case Managers in Each Region as Work Incentive Counselors

G. Restructure Psychosocial Rehabilitation Services to Include Supported Employment Evidence-Based Practices

- Work with DMAS to revise and clarify DMAS Day Support, Mental Health Support Services and Psychosocial Rehabilitation regulations, service units, and provider manuals to support ongoing employment-related behavioral health services.
- Work with DMAS to provide guidance to care coordination providers regarding supported employment evidence-based practice models, pursuant to principles outlined in the Appropriation Act.

H. Modify Waivers to Incentivize Integrated Employment to Include Regulation and Rate Adjustments

- Work with DMAS, concurrent with any modifications related to capacity expansion, to propose amendments to current waivers or develop new waivers by Fall 2011.

3. CASE MANAGEMENT

GOAL: STRENGTHEN THE CAPABILITY OF THE CASE MANAGEMENT SYSTEM TO SUPPORT INDIVIDUALS RECEIVING BEHAVIORAL HEALTH OR DEVELOPMENTAL SERVICES.

BACKGROUND/RATIONALE

- Case management (service coordination and intensive case management) is the core service that Virginians with behavioral health disorders and intellectual or developmental disabilities receive to help navigate and make the best use of the Commonwealth's publicly funded system of services. Case managers help individuals connect with the right level and intensity of services and provide day to day support to assure stable community living.
- Case management is of critical importance to all dimensions of the services system, yet this role lacks specified coursework and preparation. The term case management is used to cover a broad array of services, from temporary to intermittent activities performed by clinicians and others in coordinating care, to long-term wraparound services provided by specified case managers and service coordinators.
- Because individuals with more serious disabilities are being served in the community and the use of inpatient services has been drastically decreased, case managers today are providing more supportive counseling and crisis intervention to seriously disabled individuals, coordinating more complex plans of care and support, and spending more time monitoring the effectiveness of an entire range services to help prevent the need for more intensive and expensive interventions.
- Strengthening the case manager's role is essential to ensure that case managers have the knowledge and expertise needed to provide effective and accountable services and identify and strengthen the individual's natural support systems.
- There is no standard training for case managers in Virginia and no system for assuring that the persons who fill this role have the knowledge and skills needed to be effective. As a result, the level and quality of case management services varies widely from community to community.

IMPLEMENTATION ACTION STEPS

A. Implement Standard Case Management Definitions and General and Disability-Specific Core Competencies

- Adopt definitions recommended by the Case Management Workgroup for care coordination, basic case management, and targeted case management.
- Use adopted care coordination, basic case management, and targeted case management definitions in crafting the DMAS care-coordination initiative.

B. Enhance the Core Competencies of Individuals Who Provide Case Management Services

- Hire a curriculum development expert using existing DBHDS resources by Spring 2011.
- Establish a case management curriculum workgroup comprised of DBHDS and CSB representatives who will work with the curriculum development expert to:
    - Review existing training modules identified by the Case Management Workgroup for their suitability in addressing case management competencies;
    - Assess gaps in existing training modules based on the outline of basic and disability-specific training topics developed by the Case Management Workgroup
    - Identify training modules that would need to be developed; and
    - Recommend a curriculum to DBHDS of existing and new training modules that address case management core competencies.
- Adopt a curriculum for basic and disability-specific case management levels.
- Create new case management training modules.
- Develop on-line and on-site strategies, timeframes, and resource requirements for providing training modules.
- Work with provider groups to implement the case management training curriculum.

C. Promote Consistency in the Practice of Case Management Across the Commonwealth

- Explore options for formally recognizing the competencies of each case manager in the behavioral health and developmental services system.
    - Examine approaches used by DHP and DBHDS to certify various health professionals.
    - Provide recommendation to DBHDS to include identification of:
        - The proposed accrediting body (e.g., DBHDS or another agency or entity);
        - Regulatory and other prerequisite requirements for case manager certification; and
        - A timeframe for implementation.
- Establish case management credentialing process.
    - Determine staffing and resource requirements to implement a case manager certification process.
    - Define experience, training, and testing requirements for case manager certification and recertification:
        - Basic case management level, and
        - Advanced disability-specific case management level.
    - Create and pilot basic and advanced disability-specific case management certification tests based on competency requirements.
    - Establish administrative infrastructure for credentialing case managers
        - Administering tests based on basic and advanced;

- Certifying and recertifying case managers; and
- Maintaining certification database.

- Work with provider groups to begin implementation of case management credentialing process.

V. Other Major Strategic Initiatives

1. Health Care Reform

GOAL: PARTICIPATE IN THE WORK OF THE SECRETARY OF HEALTH AND HUMAN RESOURCES' OFFICE OF HEALTH CARE REFORM AND DEVELOP STRATEGIES TO STRENGTHEN COLLABORATION BETWEEN THE PREVENTIVE AND PRIMARY HEALTH CARE AND THE BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES SYSTEMS.

BACKGROUND/RATIONALE

- A significant number of those currently being served in Virginia's publicly funded behavioral health system do not have health insurance. As a result their access to primary health care and specialty care is limited.
- Changes to the Commonwealth's Medical Assistance Program resulting from federal health care reforms will have a significant impact on Virginia's publicly-funded behavioral health and developmental services system and the individuals served by this system.

IMPLEMENTATION ACTION STEPS

A. Continue to Support the Work of the Virginia Health Reform Advisory Council.

B. Identify and Participate in Training Opportunities at the National Level to Broaden DBHDS Understanding of Issues Related to the Patient Protection and Affordable Care Act (PPACA).

2. Sexually Violent Predator Service Capacity

GOAL: ADDRESS SEXUALLY VIOLENT PREDATOR (SVP) SERVICE CAPACITY ISSUES, INCLUDING OBTAINING NECESSARY RESOURCES TO SAFELY OPERATE THE VIRGINIA CENTER FOR BEHAVIORAL REHABILITATION AND PROVIDE APPROPRIATE SVP REHABILITATION AND TREATMENT SERVICES.

BACKGROUND/RATIONALE

- DBHDS' sexually violent predator services and the Virginia Center for Behavioral Rehabilitation (VCBR) were designed and funded to serve a SVP population that was to be identified based on four SVP predicate crimes and a projected commitment rate of about two individuals per month. However, changes to the Code of Virginia enacted in 2006 increased the number of predicate crimes from 4 to 28, increasing the number of individuals who are eligible for SVP commitment by approximately 350%.
- The VCBR census is projected to grow from 356 in FY 2012 to 738 in FY 2017.
- With the increased commitment rate resulting from this change, VCBR reached its 200 bed operating capacity in June 2010 and its census will exceed the currently available bed and program space at VCBR sometime after June 2011. No new beds are scheduled to be built before that date. In the 2011 session of the General Assembly, DBHDS was directed to implement a plan to double bunk up to 150 sexually violent predators committed to the VCBR in lieu of opening a temporary facility for the housing, confinement and treatment of civilly committed sexually violent predators at the Southside Virginia Training Center in Dinwiddie County. The Department of Corrections will assist DBHDS in developing the plan to double

bunk residents and provide risk assessment data of the affected population. The 2011 General Assembly also deferred any capital project to expand or construct additional SVP units or facilities until a comprehensive review of the current program for the civil commitment of sexually violent predators is completed. To this end, it mandated the Joint Legislative Audit and Review Commission (JLARC) to study the full SVP process including the operation of the VCBR and to report back its findings and recommendations to the Legislature no later than November 30, 2011.

- During the summer of 2010, DBHDS began an extensive review and revision of the VCBR program. As part of this a new facility director was hired in August and a new clinical director was hired in December. Since then all aspects of the operational and clinical program have been, or are being studied and plans are being made for their revision. This process has resulted in the following.
    - The facility director led a review and revision of all facility policies and procedures. Several policies have already been revised and are being reviewed by the OAG. This process is ongoing.
    - The facility director has reviewed the staffing mix and numbers and is changing where appropriate to ensure better programming and security.
    - The clinical director led a review and revision of all clinical policies and procedures and revised the overall treatment program. This has already resulted in increased treatment hours, a better utilization of staff, and a more refined program. This process is ongoing.
    - The medical director led a review and revision of all medical services to increase efficiencies and realize fiscal savings. This process has already produced a sizable reduction in out-of-facility medical trips and is creating fiscal savings. This process is ongoing.
- The DBHDS Office of SVP Services (OSVP) has begun a review of its current policies and procedures relating to screening, evaluation, and conditional release procedures. As placing more individuals on SVP conditional release is a partial solution to VCBR overcrowding, the OSVP is developing new procedures to increase use of conditional release and to support men on such release so as to sustain them more effectively. In addition, there are presently three females civilly committed as SVP and being served by DBHDS. The OSVP has taken on responsibility, in cooperation with the VCBR and Central State Hospital, to provide treatment to them.

IMPLEMENTATION ACTION STEPS

A. Meet the Near Term Needs for Additional Bed and Treatment Space at VCBR

- Double-bunk up to 150 of the existing bed rooms.
- Install beds that are currently in storage, many of which will require DOC modification.
- Purchase mattresses, wardrobes, bed covers, furniture, and equipment to meet the needs of up to 150 additional residents.
- Schedule treatment on a double-shift basis, with existing treatment staff working split shifts between day and evening to leverage the available treatment room space to meet the expanded need.
- Expand food services by about 40% on the current site.
- Review and reconfigure medical, education, and security service resources to meet the expanded need.

B. Increase Use of Conditional Release and Support Individuals on Such Release

- Create two part time OSVP positions, one to provide administrative and case management support to the OSVP and one to provide both sex offender treatment services to females committed as SVP and to support development of more conditional release plans. (Completed)
- Deploy one OSVP staff to work part-time at the VCBR to assist eligible residents in developing appropriate home plans to facilitate placement on SVP conditional release and do outreach to the community to develop housing resources for SVP on conditional release. (Completed)
- Add one new SVP Specialist in the OSVP, paid for with conditional release funding presently in the OSVP budget, to support the conditional release initiatives.

3. Information Technology - Electronic Health Records and Health Information Exchange

GOAL: DEVELOP INFORMATION TECHNOLOGY INITIATIVES TO IMPLEMENT ELECTRONIC HEALTH RECORDS (EHR) AND HEALTH INFORMATION EXCHANGE (HIE) WITH STATE FACILITIES, CSBS, OTHER PERTINENT HEALTH CARE AND PROVIDER AGENCIES, FACILITATE QUALITY MANAGEMENT, AND PERFORM QUALITY MANAGEMENT AND OUTCOMES OVERSIGHT.

BACKGROUND/RATIONALE

- In 2009, Congress passed the *American Recovery and Reinvestment Act*. The broad legislation addresses a large variety of healthcare issues, one of which is the requirement to implement an EHR system.
- With its operation of multiple facilities in various locations, DBHDS recognized that implementation within a short period of time would be problematic and decided to use a phased EHR implementation process in state facilities. The billing module (AVATAR) is complete and the pharmacy module will be completed by December 2011. Implementation of the clinical treatment/medical records module, including ancillary services must be completed by 2014 if DBHDS is to continue to bill Medicaid and Medicare.
- A primary consideration when planning for an EHR system is the need for the system to be capable of integration with other DBHDS systems, including AVATAR and the GE Centricity Pharmacy system. Additionally, the U.S. DHHS/CMS wants to extend the Medicaid Information Technology Architecture (MITA) to cover a broad array of safety net services, including behavioral health, and results from this assessment must be incorporated into DBHDS EHR planning. Finally, HIE considerations must be addressed to enable information and data to be exchanged among facilities, and eventually with CSBs through Commonwealth Gateway.
- Federal authorities have recognized that the requirement to implement and EHR/HIE system is a costly incentive. Medicare and Medicaid have provisions that will consider retrospective incentive payments that may be applicable to DBHDS. This would allow DBHDS to build in the costs related to hardware, software, telecommunications, labor, and other related cast into the daily rates of eligible facilities (training centers and geriatric units). DBHDS estimates that 60% of the anticipated hardware, software, and staffing costs can be recovered through this process. The remaining amount will need to be part of the FY 2013-2014 general fund appropriation.
- At the request of the Secretary of Health and Human Resources, over the past six months DBHDS and VDH have been exploring the feasibility of obtaining an EHR solution that can meet the needs of both agencies. This collaborative group has explored similarities and differences in the agencies' requirements and concluded that, while there are some similarities in requirements, there also are significant differences because DBHDS needs an inpatient/

behavioral health/long term care solution and VDH needs an outpatient/ambulatory health care solution. Some vendors may offer solutions that *could* meet requirements of both agencies; however, no other state has adopted a single vendor approach for both systems. Potential financial and technical advantages in pursuing a common approach may include reduced software licensing costs, lower vendor maintenance costs, and economies resulting from set-up and configuration, training, support, and implementation of a common technical infrastructure. However, higher costs may also be possible if vendors are required to modify their applications to accommodate the two agencies' requirements.

IMPLEMENTATION ACTION STEPS

A. Review Other States' EHR Approaches and Vendor Solutions

- Review of other states' EHR behavioral health activities, including Utah and Alaska. (Completed)
- Schedule demonstrations and review potential vendor solutions, including NetSmart and EPIC. (Underway)
- Issue Request for Information (RFI) to determine how vendor EHR solutions address "meaningful use" certification and Joint Commission core measures and whether then have MITA Architecture in their software and vendor behavioral health solutions. (Completed)
- Develop EHR implementation cost estimates and a multi-year funding strategy that focuses first on facilities that have the largest Medicaid-eligible patient population in order to recover the cost of implement through third party reimbursements to the extent possible. (Completed)
- Present results of the DBHDS/VHD review to the Secretary of Health and Human Resources by April 2011.

B. Develop DBHDS EHR Specifications, Assuming HHR Approval

- Perform the DBHDS MITA assessment. (Completed)
- Complete all EHR project management activities for obtaining CIO approval between May and August 2011.
- Perform workflow analysis in facilities, develop and refine system, and obtain requirements between May and August 2011.
    - Define common and unique clinical workflows across facilities and use findings for process engineering.
    - Document state facility clinical workflows.
    - Develop a template to document facility clinical workflows.
    - Conduct a pilot test of the template at Hiram Davis Medical Center.
    - Modify template based on pilot test.
    - Perform assessment in all facilities.

C. Initiate EHR Project Implementation

- Obtain final DBHDS and VDH approval of requirements by November 2011.
- Prepare Request for Proposal (RFP) between September and December 2011.
- Issue RFP by January 2012.
- Review RFP between March and April 2012.
- Negotiate and award contract between May and June 2012.

- EHR implementation between July 2012 and June 2015.
- Project management and oversight. (Ongoing)

VI. Next Steps

The Creating Opportunities implementation teams have made substantial progress in defining the various strategic initiative products and developing action steps and timeframes for their successful implementation. Over the next months, the DBHDS and stakeholders involved in the Creating Opportunities process will continue their efforts to achieve the action steps that are delineated in this report. This includes continued refinement of initiative implementation activities, collection and analysis of services system data, assessment of resource requirements for identified services system investments, development of policy and potential legislative or regulatory recommendations, implementation of training and skill development, and establishment of performance and oversight monitoring expectations.